Per Lægreid, Ståle Opedal and Inger Marie Stigen

The Norwegian Hospital Reform

Balancing Political Control and Enterprise Autonomy

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Abstract:: The paper focuses on the balance between superior governmental control and enterprise autonomy by examining the Norwegian Hospital Reform. The enterprise model and the policy instruments that the government, as owner, has for exercising power and control vis-à-vis the health enterprises are described. How the trade-off between autonomy and control is experienced and practiced is analyzed by use of survey data collected among regional executive board members, and illustrative cases. The trade-off can be characterized as ambiguous and unstable and we ask if it is possible to achieve a plus-sum game between political control and autonomy

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Preface

In this working paper one of the most comprehensive contemporary administrative reforms in Norway, the Norwegian Hospital reform, is examined. In 2002 responsibility for the Norwegian hospitals was transferred from the counties to the central government, the state. The reform also set up new management principles for the hospitals, based on a decentralized enterprise model. This paper focuses on the balance between superior governmental control and enterprise autonomy.

The paper is written as part of the project on Evaluation of National Ownership and Enterprise Model of Norwegian Hospitals at the Norwegian Institute for Urban an Regional Research (NIBR), Rogaland Research and Nordland Research, funded by the Ministry of Health, and the ATM-health project (Autonomy, Transparency and Management – Three Reform Programs in Health Care) at the Stein Rokkan Senter for social studies, funded by the Norwegian Research Council. Per Lægreid is professor at the Department of Administration and Organization Theory and research director at the Rokkan Centre, University of Bergen, Ståle Opedal is researcher at the Rogaland Research and Inger Marie Stigen is researcher at the Norwegian Institute for Urban and Regional Research. An earlier version of the paper was presented at the 17th Nordic Conference on Business Studies 14-16th August 2003, Reykjavik, Iceland. We wish to thank the participants at the workshop, researchers at the democracy and governance group (DEMOS) at the Norwegian Institute for Urban and Regional Research, Tore Hansen, University of Oslo, Tom Christensen, University of Oslo and Simon Neby, Stein Rokkan Centre for social studies for valuable comments and help.

We also wish to thank the members of the regional executive boards that answered our questionnaire.

Oslo, April 2004

Hilde Lorentzen

Research Director

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Summary

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In this paper one of the most comprehensive contemporary administrative reforms in Norway, the Norwegian Hospital reform, is examined. In 2002 responsibility for the Norwegian hospitals was transferred from the counties to the central government, the state. The reform also set up new management principles for the hospitals, based on a decentralized enterprise model.

One of the main challenges of the reform is to balance the autonomy of the health enterprises and the political control by central government. We ask how the trade-off between control and autonomy is practiced. Is it possible to fulfil the ambition of a good balance between political governmental control and decentralized autonomy, or is the balance difficult, ambiguous and unstable? The question is analyzed by use of survey data collected among regional executive board members, and illustrative cases.

The survey data and the cases studied reveal that there is a potential for ambiguity and conflict in the reform. The enterprises are loyal to the owner, but they also try to maximize autonomy. The politicians, on the other hand, experience loss of control when the enterprises live up to their autonomous role. The cases illustrate conflicts between a commercial or professional logic, furthered by the regional health enterprises; and a political logic furthered by local, regional and central politicians. In many cases autonomization is challenged by political intervention in single issues and by other political efforts in order to enhance political control.

The study show that in practice it may become difficult to live up to the principles of devolution and the official formal governance model of frame-steering and performance-management. The slogan "more steering in big issues and less steering in small issues" seems to be easier in theory than in practice. This is in line with experiences from other reforms. An unstable balance is a basic systemic feature that cannot be solved once and for all. Instead, one must expect to live with partly conflicting values.

It therefore becomes a main challenge to find out which factors affect the trade-off between central control and local autonomy. In this paper we focus on some structural factors, cultural factors and environmental factors linked to the parliamentary system in Norway. Type of policy issue and the political salience of the tasks and issues seem especially important. One main lesson is thus that context matters. The effects of structural arrangements, culture and the present parliamentary situation are dependent on the character of the policy issue that is on the agenda. If the issue has a redistributive character it seems especially challenging for the balance between political control and autonomy.

Sammendrag

Per Lægreid, Ståle Opedal og Inger Marie Stigen
Sykehusreformen
Balansegang mellom politisk styring og foretaksautonomi
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I 2002 overtok staten eierskapet til sykehusene og øvrig spesialisthelsetjeneste og innførte foretaksmodellen som overordnet organisasjonsform. Mens eierskapet tidligere ble ivaretatt av fylkeskommunene, er eierskapet nå sentralisert til en eier – staten. Reformen baserer seg dessuten på nye ledelsesprinsipper ved at sykehusene er fristilt og omgjort til selvstendige rettssubjekter, i henhold til foretaksmodellen.

En av de store utfordringene knyttet til sykehusreformen er å balansere hensynet til autonomi for de nye helseforetakene med hensynet til politisk styring fra eierministerens og Stortingets side. I dette arbeidsnotatet stilles spørsmålet om hvordan balanseforholdet mellom autonomi og politisk kontroll praktiseres i den nye styringsmodellen. Er det harmoni eller spenninger mellom disse hensynene? Utfordres modellen av strukturelle og historisk-institusjonelle forhold eller av hendelser i omgivelsene til den nye modellen? Fokus er således rettet mot de betingelser som kan påvirke og influere på forholdet mellom autonomi og politisk kontroll.

Datamaterialet utgjøres av resultater fra en survey til medlemmene av styrene for de regionale helseforetakene, og illustrerende cases.

Datamaterialet viser at det er et stort innslag av tvetydighet og potensial for konflikt i modellen. De eieroppnevnte styrene viser stor lojalitet i forhold til staten som eier. Men samtidig kombineres denne lojaliteten med et sterkt ønske om mer autonomi for helseforetakene. Tvetydighet og ustabilitet i forholdet mellom den politiske styringen og foretakenes autonomi er først og fremst knyttet til oppfatninger om manglende koordinering av statens mange roller. Med sykehusreformen er både eieransvar, finansieringsansvar, bestilling av tjenester, regulering og tilsyn og kontroll samlet hos staten. De regionale helseforetakene mener også at staten detaljstyrer foretakene i for sterk grad sett i lys av de vide fullmakter de er delegert gjennom etableringen av helseforetak. Eksempler viser at staten ikke går av veien for å intervenere i enkeltsaker. Politikerne opplever redusert politisk kontroll, og ønsker å styrke den politiske styringen i enkeltsaker. Med den statlige overtakelsen har Stortinget engasjert seg sterkere i forhold til sykehusene og helseforetakene. Det første året med statlige sykehus ble f.eks. antallet spørsmål i Stortinget om sykehus og helseforetak fordoblet.

Hvorfor synes forholdet mellom politisk styring og autonomi å være tvetydig og ustabilt? En kan selvsagt argumentere med at reformen inviterer til slik ustabilitet på grunn av reformens hybride karakter. Reformen er også så ny at det fortsatt rår usikkerhet blant aktørene om hvordan de skal forholde seg til hverandre og omverdenen. Men det er også

forhold av instrumentell og historisk-institusjonell karakter og ved omgivelsene som kan kaste lys over den tvetydighet og ustabilitet som gjør seg gjeldende.

Et eksempel av instrumentell betydning er at det i begrenset grad er klargjort hvilke enkeltsaker som skal underlegges politisk styring. Helseforetaksloven sier at saker av vesentlig og prinsipiell karakter skal behandles av helseministeren i foretaksmøte, men det ikke entydig hvilke saker dette dreier seg om. I tillegg kan det argumenteres for at den politiske styringstradisjonen på helseområdet støter mot de rådende forvaltningspolitiske strømninger om mer politisk styring i stort og mindre i smått. Både stortingsrepresentanter og helseministeren har erfaringsmessig i stor grad forbeholdt seg retten til å gripe inn i enkeltsaker – både for å markere seg politisk og få innflytelse på utfallet.

Det økte helsepolitiske engasjementet skjer dessuten i en tid hvor Stortinget har økt sin generelle aktivitet og blitt styrket vis a vis regjeringen. Både den statlige overtakelsen av sykehusene og situasjonen med mindretallsregjeringer kan forklare den økte politiske interessen for sykehusene og helseforetakene i Stortinget. Stortinget har blitt viktigere siden lokale myndigheter ikke lenger har noen formell innflytelse på sykehuspolitikken.

Sist men ikke minst, kan innslaget av dynamikk og tvetydighet i forholdet mellom styring og autonomi også å ha sammenheng med hvilke typer saker som står på dagsorden. Det er i særdeleshet saker med omfordelende virkninger som har fått oppmerksomhet, eksemplifisert gjennom sentralisering av funksjoner og mer utstrakt spesialisering av sykehusene. Helseforetakenes arbeid med denne formen for arbeids- og funksjonsfordeling har utløst spenninger mellom økonomiske og faglig-medisinske hensyn på den ene siden og hensynet til nære og tilgjengelige tjenester uavhengig av hvor folk bor på den andre.

Erfaringene så langt med den norske sykehusreformen viser med andre ord at slagordet om ”mer styring i stort, og mindre i smått” er lettere i teorien enn i praksis. Denne erfaringen deler denne reformen med flere reformer. For helseministeren innebærer sykehusreformen at han eller hun må balansere mellom en reformlogikk basert på fristilling og desentralisering og en politisk styringstradisjon basert på tett integrasjon og nærhet mellom sykehus og politikerne.

Spenningen mellom overordnet styring og foretaksautonomi kan neppe løses en gang for alle. Tidligere forskning av lignende reformer viser at dette er svært vanskelig. Den sentrale utfordringen er derfor ikke å diskutere hvordan en skal oppnå en slik balanse, men å se nærmere på de faktorene som påvirker denne balansen. Her må fokus rettes både mot de grunnleggende forutsetninger som den rådende modellen bygger på, og under hvilke betingelser så vel instrumentelle, institusjonelle og mer politiske faktorer påvirker balanseforholdet.

1 Introduction

New Public Management (NPM) has many facets and embraces a number of different reform components. It prescribes centralization and control as well as decentralization and autonomy. There is thus a tension in NPM between the need for greater managerial flexibility and discretion, and the need for a greater degree of political accountability and control (Christensen and Lægreid 2001a). On the one hand there seems to be a widespread belief that autonomization can enhance performance, accountability as well as political control. On the other hand, systematic evidence for some of the promised benefits is very patchy (Pollitt et al. 2001). In this paper we will examine on one of the most comprehensive contemporary NPM-inspired reforms in Norway, the Hospital Reform.

In 2002 responsibility for the Norwegian hospitals was transferred from the counties to central government. The ownership was thereby centralized to a single body – the state. The reform also set up new management principles for the hospitals based on a decentralized enterprise model. One of the main challenges of the reform is to balance the autonomy of the health enterprises and the political control by central government. On the one hand the Minister of Health has the full responsibility for conditions in the health sector and a new department of ownership has been established; on the other the enterprises are given enhanced local autonomy with their own executive boards and general managers with powers of authority to set priorities and manage the regional and local health enterprises. The reform involves a strengthening of overall central government ownership responsibilities and control simultaneously representing a decentralized system of management.

The focus of this paper is on the balance between superior governmental control and autonomy for the health enterprises. We ask how the trade-off between control and autonomy is practiced. Is it possible to fulfill the ambition of a good balance between political governmental control and decentralized autonomy, or is the balance difficult, ambiguous and unstable, due to different structural, cultural and environmental conditions?

The Hospital Reform is still a novel one and is passing through a phase marked by interpretations and adjustments among the actors within the new structural framework. We therefore focus on the achievements or effects that eventually accrue from the process of the reform. We will discuss the transformation of the administrative apparatus both as a result of the structural features and as a more direct consequence of environmental factors and the historical–institutional context. We ask: Under what conditions is the balance between political control and enterprise autonomy influenced and altered?

First, we outline three perspectives on administrative reforms. Second, we place the reform into the Norwegian context and present a brief history of developments leading to the present reform. We describe the enterprise model and give a description of the policy instruments that the government, as owner, has for exercising power and control vis-à-vis

the health enterprises. Third, we examine and analyze how the trade-off between autonomy and control is experienced and practiced so far – by use of survey data collected among regional executive board members, and illustrative cases. In the fourth section we discuss based on the theoretical perspectives why the trade-off can be characterized as ambiguous and unstable. Finally we conclude by asking if it is possible to achieve a plus-sum game between political control and autonomy.

The empirical basis of the paper is official documents on the reform and a mail survey conducted in May 2003 to all 45 members of the five executive boards of the regional health enterprises. The response rate is 80 %. The case studies are based on public documents and press releases issued by the parliament (*Storting*), the Ministry of Health, the health enterprises, together with information from their web sites and media coverage in national and regional newspapers and the Norwegian Broadcasting Corporation (Neby 2003).

2 Theoretical perspectives

We use three different theoretical approaches to explain and support our arguments: an instrumental approach emphasizing the formal and hierarchical aspects of the reform; an institutional approach stressing the cultural features of the reform and the health sector, and an environmental approach bringing up arguments connected to characteristics of political processes and policy types.

According to an *instrumental view*, public organizations change because actors have a relatively strong influence on decisions and implementation, unambiguous intentions and goals, clear means and insights into the possible consequences of various solutions, resulting in effects that mostly fulfil the stated collective goals (March and Olsen 1983). The decision-making is characterized by tight control of the actors involved and unambiguous organizational thinking concerning the structural changes made (Olsen 1992). From an instrumental perspective specific goals provide clear criteria for selection among alternatives, and formalization structures the relationships among the set of roles and principles that govern behaviour in the system. This makes behaviour predictable and unambiguous through standardization and regulation (Scott 1987).

An active administrative policy encompasses elements of both control and rational calculation (Dahl and Lindblom 1953). It assumes that the organizational form to be used is open to conscious choice, implementation and control by central political-administrative actors; second, it assumes a tight coupling between goals and means, which are fulfilled through different organizational forms; third, it assumes that different organizational forms have different effects; and fourth that there are criteria which could be used to assess those effects (Christensen, Lægreid and Wise 2002).

These assumptions are difficult to fulfil in practice. The leeway political leaders have in reform processes are influenced by historical-institutional contexts and environmental factors. We will therefore argue that reform processes are not characterized by a simple instrumental view of organizational decision-making and change seen as administrative design: rather, they can be understood as a complex interplay of purposeful choice constrained by internal and external factors.

One set of constraints is represented by the historical-institutional context or cultural tradition, norms and values that can have major impact on the instrumental features of an active administrative policy. An *institutional perspective* focuses on the cultural features of organizations; frequently on how culture serves to make them stable, integrated and robust towards fundamental changes (Selznick 1957, Krasner 1988). Reforms may have norms and values that are highly incompatible with the traditional cultural norms and values of the political administrative systems of specific countries, resulting in difficulty in making reform decisions or implementing reforms, or in the modification of reform elements (Brunsson and Olsen 1993). But cultural and institutional features of organizations may also have the potential to further instrumentally planned reforms (Veenswijk and Hakvoort 2002).

Environmental characteristics are also potentially important for developing and implementing administrative reforms. The degree of ambiguity and stability in the relationship between political control and enterprise autonomy can thus be discussed in an environmental approach bringing up the political processes that occur in the task environment. An environmental approach stresses that organizations exist in a dynamic and interdependent relationship with actors and groups in the environment. To understand 'organizational environment' one has to take into account the characteristics of the environment (Olsen 1992). We pay special attention to the relationship to the Parliament, to local pressure groups, to lobbyists and to the role of media. Controversial issues, scandals and unforeseen situations have on several occasions caused strong mobilization of political parties, media debate and growth of local pressure groups. Negotiations and external pressure can potentially both enhance and hinder political and managerial control: leaders may intentionally build winning coalitions with external groups and actors, but external pressures may also result in socialization and aggravation of conflicts (Schattschneider 1960). According to Lowi (1964, 1972) "policy determines politics". Public policies can be distinguished by their effect on society, whether costs and benefits are narrowly or broadly dispersed, and by the relationship among those involved in policy formation. The policy types create and identify winners and losers to various degrees. The level of conflict is especially high in redistribution policies involving efforts by the government to shift the allocation of wealth or rights among groups of the population. When a policy has redistributive effects, winners and losers are distinct, and the potential for conflicts and political intervention is high.

When hierarchically-based instrumental reform processes run into problems, it is usually because of heterogeneity, either internal or external. Political and administrative leaders may have different opinions of how to implement the reform; there might be a cultural collusion between the reform ideas and traditional norms and values in the hospitals, or there might be turbulence and disagreement among actors in the environment. This can modify policy capacity and rational calculation. Reform processes can be difficult to control and ambiguity in organizational thinking may increase.

3 The Reform context

Norway has been seen as a reluctant reformer (Olsen 1996). Until 1992 major public domains like the railways, telecommunications, the power supply, postal services, forestry, grain sales and public broadcasting were organized as central agencies or government administrative enterprises. But since the mid-1990s greater autonomization and agencification have become major components in the Norwegian-style New Public Management. The Norwegian reform process consists of a combination of internal delegation of authority to agencies – with a more performance-assessment regime – and external structural devolution through the establishment of state-owned companies (SOCs) (Christensen and Lægreid 2001a, 2001b, 2002). As a result of the public reforms, more autonomous and controlling agencies have also been established. Following the examples of New Zealand (Boston et al. 1996), the single-purpose model has increasingly replaced the former integrated civil service model where functions of the owner, regulator, controller, purchaser and provider were all performed by the same organization.

The commercial parts of the government administrative enterprises mentioned above have all been corporatized, i.e. established as various types of SOCs, while the regulatory parts have retained their agency form. The hospital reform is, together with road construction and air traffic control, the latest examples of this development. The hospital reform is thus inspired by NPM, focusing on how to make the hospital efficient by introducing the business model and framework steering as a main political-democratic control device.

Like the reform of other parts of public administration, the health reform is something of a hybrid, prescribing both centralization, by transferring ownership from the regional level to central government, and decentralization, by changing hospitals' form of affiliation from that of public administration bodies to autonomous health enterprises. The reform has two faces– one that prescribes better governmental control and one that prescribes more autonomy to the sub-levels of the enterprise.

3.1 Centralization: From county to state ownership[1]

Like Sweden and Denmark, Norway has followed a pathway with a history of relatively decentralized and welfare-oriented health care system (Byrkjeflot and Neby 2003, Pedersen 2002). The takeover of responsibility for all Norwegian hospitals by central government marked the end of 30 years of ownership by the 19 counties and may signify

[1] Sources: The Norwegian Hospital Reform – Central government assumes responsibility for hospitals; http://odin.dep.no/shd/sykehusreformen, P. Hellandsvik: "New Health Organization in Norway. Government Run hospitals. Consequences for research and health services." Lecture held at Nordic Meeting for Deans and Teaching Hospitals, Reykjavik August 31 2001; http://odin.dep.no/odinarkiv and Opedal og Stigen (2002ac).

a break with the common Nordic decentralized model of health care. The counties were assigned responsibility for institutional health services in connection with the introduction of the Hospital Act on January 1. 1970. Norway was divided into five health regions in 1974, and there was a voluntary regional cooperation between the counties up to 1999 when this cooperation was made mandatory.

The question of takeover of responsibility for hospitals by central government was evaluated several times – first in 1987, then brought on the agenda in 1994 and evaluated once again in 1996. Only a minority voted in favor of increased freedom and overall state control. In the year 2000, however, a political process started that resulted in the new Health Enterprise Act of June 6, 2001.

The Labour Party came into power in Norway in March 2000 with the Stoltenberg minority government. At its national congress in November 2000 the party decided to support takeover of hospitals by central government. The reform was then prepared and implemented at a rapid pace. Public hearings were held during the winter of 2001 and the necessary parliamentary majority was obtained in June. The novelty of the reform was the change of ownership combined with structural devolution (Opedal and Stigen 2002a).

There were several arguments for state ownership. First, the health sector is characterized by increasing use of resources, combined with continuous financial strain. The counties were owners, but in practice the central government had the financial responsibility (Hagen 1998). This resulted in unclear divisions of overall responsibility. The relationship between the state and the counties was often labeled the "Old maid game". The hospitals were the largest budgetary component in the counties, making them a burden in times of economic hardship and resulting in unpredictable lobbying of the *Storting* for increased financing. Second, the development of professional specialization of medical health made it necessary to organize the flow of patients across county borders and create larger units of coordination with more formal responsibility than the former health regions held. Third, the variations between the counties in the medical services offered were too broad, and access to health services depended on place of residence. It was, in other words, difficult to attain the national goal of standardization in the hospital sector. Fourth, the counties executed their ownership in different ways. Some practiced management by objectives while others exercised more detailed control vis-à-vis the hospitals (Carlsen 1995, Opedal and Stigen 2002a). There were also large differences in the utilization of financial resources between the counties.

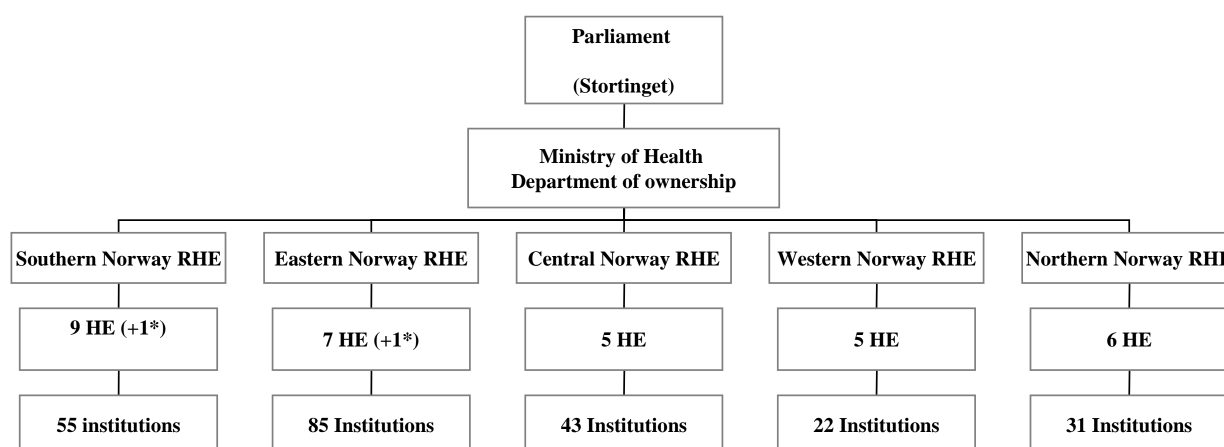
The aim of the state ownership was thus to come to grips with what was seen as unclear divisions of responsibility, different and ineffective use of financial resources, and disparate access to health services in the population. The running of the hospitals was attacked for being overly influenced by regional politicians with a low level of competence, for lacking professional administrative leadership and for being inefficient.

3.2 Decentralization: From public administrative bodies to health enterprises

The hospitals also changed their organizational form from public administration entities to become parts of health enterprises. The new pattern of hospital organization envisages the Ministry of Health as the owner of the hospitals, with an ownership department in the ministry as the location of administrative responsibility. Under the ministry five regional health enterprises with separate professional boards have been established, and in turn

these have organized approximately 250 institutions into 33 local health enterprises under regional auspices (Figure 3.1).

Figure 3.1 *The Health Enterprise Model. RHE=Regional Health Enterprises. HE=Health Enterprises *Eastern Norway RHE and Southern Norway RHE own one pharmacy enterprise in common*



The health enterprises are separate legal entities and thus not an integral part of the central government administration. Fundamental health laws and regulations, policy objectives and frameworks are, however, determined by the central government and form the basis for the management of the enterprises. The organization of the enterprises stipulates in several ways how the owner may exercise control.

First, central government appoints the regional board members. No politicians are members of the boards; the only group that has any formal representation is employees of the enterprises. There has been some debate on the composition of the boards – stressing that businessmen have replaced political representation. Table 3.1 shows the actual background of the board members and where a majority of members have an occupational background from the public sector. To a large extent the majority is due to the representation of employees. If these members are excluded from the calculation, there is a greater balance between the number of members with occupational background from public and private sectors.

Table 3.1 *Regional executive board members: Occupational background.Percentages*

	All	Excluding employee representatives
Public sector	64	46
Health Sector	*42*	*13*
Other parts of public sector	*22*	*33*
Private sector	24	37
Retired	4	7
Unknown	7	10
N=100 %	**45**	**30**

Second, the owner exercises control through the health enterprise Act, through the articles of association, steering documents (contracts), and through decisions adopted by the enterprise meeting. The ministry has attempted to separate a formal steering dialogue (the "line dialogue") from the more informal arenas of discussion (the "staff dialogue") (Opedal and Stigen 2002b). Third, the state finances most of the hospital activities, and there is also, of course, a formal assessment and monitoring system – with formal reports on finances and activities to the ministry.

The intention is that the formal policy instruments of central government should be strongly regulated. This is meant to safeguard the enterprises from detailed control on the part of the owner and help to give them genuine responsibility for their own actions. The principal idea of the reform is that the enterprise organization and the new management principles will reduce day-to-day management to the advantage of principal issues relating to priorities and hospital structure. Together with greater transparency this is intended to allow for "more steering in big issues and less steering in small issues". Of importance for the central government is to gain a stronger grip on management in relation to the structure of the health service, for example by means of the distribution of functions.

At the same time the managers of the enterprises are given greater responsibility and freedom within the framework and structure laid down. The empowerment of the managers implies discretion for managers and boards and only limited involvement of the politicians. The burden on the political leadership is thus intended to be reduced, and through a sharp division between politics and administration, political control may increase. The enterprises have their own responsibilities as employers and are responsible for use of capital. The enterprises are also responsible for their own finances subject to the proviso that they cannot go into voluntary liquidation. The purpose of organizing the hospitals as enterprises is thus to decentralize the management process, produce more efficient management, improve access to information, and delegate financial responsibility within health policy objectives and frameworks. Through autonomization the intention is to achieve less bureaucracy, an improved ability to manage change, and enhanced user information. At the same time, through its new roles central government must secure overall coordination wherever this is necessary and appropriate. In official presentations of the reform it is emphasized that the reform does not involve privatization of the hospitals operations: on the contrary, the reform means a tightening of current legislation. The Health Enterprise Act includes one provision which states that hospital activities cannot be transferred to private owners without the permission of the *Storting*.

Last, but not least, it has to be underscored that the mainstay of control of the executive and central government by the legislature is the principle of ministerial responsibility.

This principle implies that the minister is responsible to the *Storting* for everything that goes on within his or her ministry and in subordinate agencies and authorities. As such, he is accountable for how the administration performs its functions and tasks. This potentially implies strong vertical co-ordination and strong sector ministries, something which may well challenge the autonomy of the health enterprise.

In summary the reform provides for decentralized management and delegation of financial responsibility at the same time as the Minister of Health, in theory, can instruct the regional health authorities and overturn Board decisions in all cases (OECD 2003). Consequentially the reform appears to represent a break with the stated goals of greater autonomization and delegation under the modernization program for the public sector. A key challenge is how to balance the autonomization of the management process and the delivery responsibility with the centralization of control and policy issues. We see the content of the reform as consisting of potential inconsistencies, a tension between centralizing and decentralizing economic ideas.

4 Political control and enterprise autonomy – some experiences

How stable is the trade-off between political control and enterprise autonomy, and under what conditions does the balance change? The existing grey zone of authority between the central political executives and the regional health enterprises makes several trade-offs possible. Since the reform prescribes both centralization and decentralization it is an open empirical question if the politicians' control over hospitals will be weakened or strengthened in practice. One main argument for answering "yes" is that structural devolution changes the instruments of control and increases the distance between the political leadership and subordinate units (Egeberg 1989). On the other hand, through state ownership and extensive use of contracts, political leaders are supposed to specify targets and objectives more clearly, and performance is to be controlled by use of quantitative indicators for monitoring results and measuring efficiency.

First, we will describe the experiences of the regional executive board members two years after the reform. How do they look upon the relationship between the Ministry of Health, the Parliament and the health enterprises? Second, we focus on selected cases in which a delegation of political authority could be said to have produced unsatisfactory results leading to trouble with the Parliament, the media and public opinion. These controversial cases are presented in the last part of this section.

4.1 The broad picture as seen by executive board members of regional health enterprises

The board members contact pattern may give us a first impression of where the board members focus their attention (Table 4.1). The board members have most frequently contact with the local health enterprises but also have frequent contact with the media. Least contact is with politicians in Parliament and the Ministry of Health as well as other central agencies. It is, however, more surprising from an instrumental perspective that the board members seem to have just as much contact with the former owners of the hospitals (local government) as the new owner (Ministry of Health). They also have as much contact with the parliament as they have with the ownership department, the Ministry of Health. Seen from an institutional point of view this is more understandable, illustrating path dependency and cultural trajectories.

Table 4.1 *Frequency of contact by board members of regional health enterprises with various groups of actors. N=36 (average). Percentage*

	monthly or weekly contact
Central government:	
MPs	11
Political leadership of Ministry of Health	8
Ownership department of Ministry of Health	14
The Norwegian Directory of Health and Social Affairs	0
The Norwegian Board of Health	3
The health enterprises:	
Board members of other regional boards	33
Board members of local health enterprises in the region	44
The administrative leadership of the local health enterprises in the region	61
Employee organizations	44
Regional user/patient committees	6
External actors:	
User/patient organizations	17
Local government	17
Media	39
Local pressure groups	17
Private health enterprises	9

To what extent does this pattern of contact indicate the influence of these groups of actors on decisions made by the regional health enterprise board? This is shown in Table 4.2. The results are quite different from the pattern of contact. Even though the board members have only minor contact with central government, compared to the health enterprises, the influence of central government is considered substantial. Especially the political leadership of the Ministry of Health have high influence according to the regional board members. This indicates that anticipation and autonomous adaptation might be important in understanding relations between the health enterprises and central government institutions. But most important for the outcome of decision-making is the board of the regional health enterprise itself. Thus, in their own eyes they are important actors with substantial influence on decisions made by the regional health enterprise.

Table 4.2 *What influence different actors have on the decisions made by the regional health enterprises. N= 34 (average). Percentage*

	Percentage answering that the actors have high or some influence
Central government:	
Parliament	73
Political leadership of Ministry of Health	88
Ownership department of Ministry of Health	79
The Norwegian Directory of Health and Social Affairs	38
The Norwegian Board of Health	36
The health enterprises:	
The administrative leadership of the regional health enterprise	84
The board of the regional health enterprise	97
Employee organizations	37
The local health enterprises in the region	50
The regional user/patient committee	36
Other regional health enterprises	0
External actors:	
User/patient organizations	24
Local government	3
Media	3
Local pressure groups	0
Private health enterprises	3

It is also worth noticing that external actors such as local government, the media and local pressure groups, attach almost no importance at all regarding the decisions made by the regional health enterprises. These results may indicate that the board members have a strong loyalty towards their owner (Ministry of Health), but still control the outcome of the decision-making within the frame-steering by the central authorities. Thus, the influence pattern reflects central components of the reform, as expected from an instrumental perspective.

More specifically, how do the board members consider the relationship between the Ministry of Health and the regional health enterprises? Table 4.3 includes some assertions about this specific relationship in the new organizational model. Most noteworthy are the results of the assertions of enterprise autonomy and central control. On the one hand, a majority of the board members agree with the assertion that they have considerable autonomy. On the other hand, a clear majority claim that the steering document from the Ministry of Health is too detailed. The results may indicate that the autonomy of the regional boards is high, but that the board members wish for even greater autonomy.

Table 4.3 *How the board members of the regional health enterprises judge the relationship between the Ministry of Health and the regional health enterprise. N=35 (average). Percentage.*

	Percentage answering that the actors have high or some influence
There is a positive relationship of trust between the regional health enterprise and the Ministry of Health	66
It is often questioned whether it is the Ministry of Health or the regional health enterprise that is responsible for an issue	9
The regional health enterprise has considerable autonomy	61
The steering document from the ownership department of the Ministry of Health is too detailed	75
The management of the Ministry of Health is difficult to predict	31
The policy signals from Parliament, Ministry of Health, directorates and central agencies, are very often contradictory	45

Another challenge for the relationship concerns the policy signals from the Ministry of Health. Almost half of the board members agree in the assertion that the policy signals from Parliament, Ministry of Health, directorates and central agencies, very often are contradictory. The Minister of Health operates both as an owner, a financier and as a regulator and the minister himself pronounces that it is in practice difficult to balance the different roles at the same time.[2] It is also worth mentioning that the board members are divided on the question about the relationship between the enterprise and the ministry. 47 percent of board members say that there is full or part agreement between the Ministry of Health and the boards of the regional enterprises; the other half report disagreement (not shown in the table). Despite this, the division of responsibility between the Ministry of Health and the regional health enterprise does not seem to be problematic from the board members' point of view.

We also asked the board members more generally about challenges that the Hospital Reform may be confronted with. The main challenge for the Hospital Reform, as the board members see it, is a situation where political demands for expansion in hospital activity is combined with slim grants and possibly causing a situation where the board is unable to act (Table 4.4). Another challenge, as a majority of the board members see it, is a lack of coordination of the different roles of the state. As we have seen, the state has accumulated a wide range of different roles – as owner, purchaser, controller and regulator. The roles of the state also include financing most of the activities in the hospitals. In practice it is difficult to distinguish between the "line dialogue" and the "staff dialogue" as intended by the Ministry of Health.

[2] Speech held by the Minister of Health, Dagfinn Høybråten, at the health enterprise managers' annual meeting 2002.

Table 4.4 *What kind of challenges confronts the Hospital Reform as viewed by board members of the regional enterprises. N=35 (average). Percentage*

	Percentages that fully or partly agree
Scarce grants combined with political demands for growth in hospital services is the biggest threat for the hospital reform	84
The coordination of the different roles of the state, as owner, regulator, controller, auditor and purchaser, is insufficient	66
The regional enterprise does not have enough authority to manage the local health enterprises in an effective way	14
The organizational culture of the local health enterprises is a barrier to change	44
There is a lack of political support when it comes to closure or merger of local health services, e.g. maternity services	62
As an attempt to avoid political conflict, the regional enterprise does not put controversial issues on the agenda	8
Protests from local government and local pressure groups make a barrier when it comes to implementation of closure or merger of health enterprises	15

A third important challenge is lack of political support when it comes to controversial issues, i.e. closure or merger of health services, thus illustrating the external political pressure affecting the implementation of the hospital policy. Protests from local government and local pressure groups do not; however, seem to constitute a problem for the majority of the board members. The problem is held to be the politicians when it comes to controversial issues. And as the board members see it, they themselves do not constitute a problem. Only a few of the board members agree with the assertion that as an attempt to avoid political conflict, the board does not put controversial issues on the agenda. In accordance with an instrumental view, they do not agree with the assertion that the regional enterprise does not have sufficient authority to manage the local health enterprises. More challenging is the organizational culture of the local health enterprises, as expected from an institutional approach. Roughly 40 percent of the board members claim that the culture is a barrier to change and modernization of the local health enterprises.

In summary, the new pattern of hospital organization envisages the Ministry of Health as the owner of the hospitals; the boards of the regional enterprises assign considerable influence to the Ministry of Health, and they also seem to be very loyal towards their owner. Central government is held to be more important than the local health enterprises and external actors like local government, media and local pressure groups, but the boards also claim to be strongly autonomous. They seem to combine an autonomous role with a strong loyalty towards the Ministry of Health, something which is not surprising since the Ministry of Health appoints the members of the boards.

But the data also indicate that the trade-off between political control and the autonomous role of the regional enterprises might be unstable and changeable. The organization of the

enterprises and the ownership by the state do not seem to fully safeguard the enterprises from detailed control by the owner. The Ministry of Health stipulates a detailed steering document that keeps track of the annual financial transfers from the government to the health enterprises. In addition, insufficient coordination of the different roles of the state and lack of political support in controversial issues, constitute challenges for the new organizational model.

In the next section we present a number of cases that serve to illustrate the tension between political control and enterprise autonomy, and underline the importance of communication and co-operation between the central government and the enterprises.

4.2 Cases illustrating autonomization and political control[3]

The Dentosept case. In 2002 a hospital infection affected a large number of patients in 14 hospitals, the source of infection being a mouth swab. Between 140 and 180 patients were affected and 12–15 succumbed to the infection. This crisis caused a public outcry and it was high on the media agenda for several weeks. It soon became obvious that the case could not be handled through the formal channels of steering and control: there was a need for stronger hierarchical supervision and instruction as well as more informal and dynamic communication between the ministry and central authorities and the health enterprises. Because of the publicity and strong media pressure the political leadership in the Ministry of Health felt a strong need to intervene and to make its handling of the case transparent both to the general public and to the *Storting*. The ministry established an ad hoc working group to handle the case and the minister delivered a special report on the case to the *Storting*. There was a clear tension between the autonomous role of the individual health enterprises on the one hand, and the need of central political control and supervision on the other. Besides, the case illustrates the rift between the government as an owner and as a regulator. In crises like this there is a need both to clarify the accountability of the ministry and the political leadership, and to leave discretion for justified actions within the autonomous health enterprises.

Closure and merger of local health services. Several of the regional health enterprises have proposed closing down health services and to concentrate health service facilities in central areas. This has resulted in local resistance and lobbying activity in an attempt to increase ministerial control over these enterprises. Several cases illustrate this dynamic. One is the initiative taken by the health enterprises to close down and centralize the maternity wards both in the rural districts and in Oslo itself. This resulted in a campaign across party lines by female members of parliament to prevent the closure of maternity services. The members of parliament in fact operated more or less as a lobby against the health enterprises.

The reorganization and merging of maternity services is especially problematic in the north of Norway with its large administrative areas and dispersed settlements. In this region the local policy aspects and local and regional policy interests have been strong in the reorganization debate. There has been a strong local lobby and the Ministry of Health has pointed out to the regional enterprise that it would be ”wise” to include local community actors in hearings and discussions about the reorganization of hospitals.

[3] The presentation of these cases is based on Christensen and Lægreid (2003a, 2003b). See also Neby 2003.

Similar processes are observed when the health enterprises try to close down local hospitals. In 2002 the Mid-Norway Health Enterprise decided not to renew its contract with a local psychiatric institution. This resulted in criticism from the municipality where the institution was located and its MP asked the *Storting* how far the health enterprises could go in closing down the health services. When urged to intervene the Minister of Health referred to the formal procedures for controlling the health enterprises, but stressed the need for good dialogue between all involved parties. He was reluctant to overrule the decision of the health enterprise as long as the needs of the patients were being met and he referred the case to the chief county medical officer to check whether this was the case. But steering signals are still sent through informal channels. In a TV debate, the Minister of Health stated that in his opinion the regional health enterprises had undertaken actions in closures and mergers which were too radical compared to his intentions. This opinion has been emphasised and made more specific in enterprise meetings between the political leadership of Ministry of Health and the regional health enterprises.

Following a cautious start the minister seems to be more willing to intervene more directly in cases of merger or closure of emergency- and maternity wards. In a few cases the minister has actually overruled decisions of the regional boards partly following pressure by the media as well as demonstrations and powerful protests from local lobby groups. On the top of that the *Storting* seems to be more willing to instruct the ministry in the event of closures, mergers and reorganization of local hospitals.

National co-ordination of purchasing systems. Another interesting case is the establishment of common purchasing systems for all of the health enterprises – for advantages of competence and economies of scale. Owing to regional policy considerations the ministry wanted to establish this unit in Vadsø, a small town in the northern-most county. There was a strong local lobby behind this location, but the whole idea was very unpopular among the health enterprises, and they managed to reduce the size of the unit. The minister announced that it was up to the health enterprises to make a unified decision, but he also made it clear that the ministry would not hesitate to direct the decision if necessary. In this case the ministry put strong pressure on the health enterprises, favouring central control at the expense of enterprise autonomy.

Controversial lobbyism and "cheating" on DRG (Diagnosis Related Groups Classification). Lobbying can take many forms. One particularly crass example was when one of the health enterprises engaged a former health politician and member of parliament, now health enterprise board member, to lobby the government in a tussle with another health enterprise over patients. When the Minister of Health became aware of this activity he immediately put a stop to it, saying it was unacceptable for enterprises to employ lobbyists to influence their own owner. The same regional health enterprise also made the controversial move of commissioning reports from two business colleges to argue against and oppose the owner, the ministry. But the most controversial case related to this regional health enterprise, headed by a former top civil servant in the Ministry of Health and Social Affairs, was the case of cheating on the DRG-system. DRG is a system whereby medical doctors code each and every patient's disease according to a complicated typology of diagnoses. The more severe diagnosis, the more the hospital is reimbursed, something that obviously leads to many intricate strategies to obtain more money from the government. In this case, a subordinate doctor proposed to the health enterprise a new "creative" way of coding, something that the director and some single enterprises accepted. When this somewhat audacious method of cheating on the system was revealed, the minister mounted an investigation and the board of the regional health enterprise was instructed by the minister to react and report back. The director was

strongly criticised and was stripped of many of his board chairmanships. Some single enterprise leaders were dismissed and "supplementary" grants are to be paid back.[4]

These cases indicate first of all that it is difficult to limit central steering to formal arrangements only such as the enterprise meeting once a year, and the steering documents. Added to this there seems to be a dynamic informal steering dialogue going on. Second, the formal frames do provide the health enterprises with some autonomy as indicated by the cases of mergers and closures of local health services. Third, crises like the Dentosept case necessitating immediate action clarify the balance between autonomy and control. Fourth, there are clear options for political control in spite of the formal autonomy of the health enterprises as illustrated by the establishment of the unit for national coordination of purchasing. Finally, the cases illustrate that environmental factors like media coverage affect the agenda setting and the trade-off between autonomy and control. Normally, cases that receive high public attention tend to strengthen the political control component, and not only in cases of principal importance (Neby 2003).

To sum up: One intention of the reformers was to put politicians at arm's length by excluding the regional council from the decision-making process and regional party politicians from the boards of hospitals. Although they have succeeded in doing this, political involvement is now tending to reappear in the form of local lobby groups and in an increased focus on health policy by members of parliament, thus challenging the balance between enterprise autonomy and central political control that the reform agents wanted to establish. Besides, more central control by the political executives is also looming because many of the cases shown decreases their legitimacy.

[4] This does not seem to be a unique case. A study from SINTEF Unimed indicate that three out of five hospitals practice some kind of creative coding to increase the funding (Aftenposten 17.6 2003)

5 Why ambiguity and unstable balance between enterprise autonomy and political control?

Our survey-data showed that the regional board members seem to combine an autonomous role with a strong sense of loyalty towards the Ministry of Health. At the same time they report detailed control from the owner, insufficient coordination of different roles of the state and lack of political support in controversial issues. This ambiguity is further illustrated in the case studies, which also revealed that the trade-off between the autonomous role of the enterprises and political control seems somewhat unstable and unpredictable. The relationship can therefore be characterized as dynamic – open to change and modification.

In this section we ask *why* the balance appears ambiguous and open to pressure based on the different perspective on administrative reform. It can be argued that it is not a great surprise that the balance is unstable and ambiguous, considering the hybrid nature of the new model. This reform, like the other NPM inspired reforms, has its roots both in the centralizing tendencies of contractualism and in the decentralizing tendencies of managerialism (Aucoin 1990; Hood 1991). And as mentioned earlier, ambiguity may also be caused by the fact that the reform is still a novel one. More interesting than documenting ambiguity is to ask under *what conditions* is the balance threatened – is it possible to understand and predict when the balance may be upset? We argue that the balance is due both to instrumental, cultural and environmental conditions. From an *instrumental perspective* a central feature of the reform is the formal basis of the relationship between the owner and the health enterprises as specified in the Health Enterprise Act, the articles of association, the steering documents and the general enterprise meeting. The question is if these documents and formal arenas of communication define a clear division of responsibility between the owner and the enterprises. Has the new Act and other formal arrangements clarified the former grey zone between the political executives and the health care institutions?

The Health Enterprise Act states that major and principal issues always should be presented to the owner for final decision. These are major issues concerning health policy in general, research and education, and other cases of high social importance. In the articles of association some specifications are made. One example is the major changes in the organization, dimensioning and localization of the health services. But despite these specifications, we would argue that the room for discretion and ambiguity is quite large. Neither in the preparatory legislative work nor in the articles of association is there a clear and unambiguous definition of what is defined as a major and principal issue. Even though the respondents' claim that the formal division of responsibility between the owner and the enterprises is quite clear, it is possible to question which issues have to be presented to the owner. There is, as such, a considerable leeway for different practice and

interpretation. Correspondingly, many aspects of autonomy are not regulated in the formal framework of the reform. The trade-off between autonomy and control is therefore subject to continuous interpretation and adjustment, depending upon the situation and the issues on the agenda.

To regard the Hospital Reform as the result of a deliberate plan by politically elected leaders with comprehensive insight into the effect of the chosen organization model and power over the reform process would be to present an incomplete picture. Politicians do not live up to the ideal preconditions of an active administrative policy, but this does not mean, however, that the idea of political choice and instrumental design has no explanatory power in this case. Through the power to intervene in individual cases and the use of indirect control mechanisms such as regulating the decision-making process, political leaders succeed in preserving a certain degree of latitude, albeit constrained by cultural features and environmental pressure.

From an *institutional perspective* it is important to focus on the compatibility between the reform content and the established traditions within this policy area. The change of ownership as well as the introduction of the enterprise model challenges the traditional way of organizing hospitals in Norway. We should expect some kind of a cultural collusion, robustness and historic inefficiency when the reform encounters cultural constraints. This would particularly be the case in the ambiguous transition period of the initial years after the reform was launched and before it has settled into a new phase of equilibrium. The hospital reform is currently in its second year and it may well be argued that ambiguity between control and autonomy is also partly due to a cultural conflict between the former public administration regime and the new enterprise regime. The system has not yet developed a unique soul or identity, serving to create and maintain a grey zone between political control and autonomy.

We would argue that the health care sector is experiencing a process of new identity building that can explain why there is ambiguity between control and autonomy. The enterprises have, on the one hand, changed names, corporate images and location (cultural artefacts). Through this process, one has tried to create a new identity for the organizations involved. It is stressed that the hospitals have become new entities with a new independent status, their own personnel and staffing arrangements, their own corporate image and own board of directors – one has tried to create a new corporate identity. On the other hand we witness tendencies of "path dependency": we have interpreted our survey data as evidence of a clear loyalty towards the owner. This loyalty, however, may also be interpreted as evidence of a traditional culture in the sector. Traditionally, there has been a close and near relationship between the health institutions as public entities and the former owners of the hospitals – the counties (Carlsen 1995, Martinussen og Paulsen 2003). As a core part of the welfare state, health policy has gained much attention among central politicians, both at ministerial level and in the *Storting*. One might thus argue that the culture so far favours political control more than autonomy. The actors in the health sector are used to making appeals to the ministry and MPs when principal and difficult issues are put on the agenda. It is also worth mentioning that a significant number of administrative employees in the enterprises were previously employed in the county health administration (Opedal and Stigen 2002b).

Likewise, it seems somewhat difficult for the politicians to accept that the reform for which they had voted actually states that the politicians are supposed to practice "hands off" to a greater degree than hitherto. The NPM ideas of autonomization set some limits for state ownership. Devolution and increased power to the executive boards place clear demands on how politicians should engage in an issue that has been transferred to the

health enterprises. Devolution presupposes that the role of the politicians is more principal and long-term, and that there is a clear division of responsibility between politics and administration. Politicians are supposed to formulate goals and visions, while implementation is left to the administration (Boston 1996). The hospital reform assumes that the MPs role is restricted to principles of management, and that they do not intervene and become embroiled in details as was often the case under county ownership (Carlsen 1995, Ot. prp. 66 2000-2001).

The new and more strategic role for the politicians does, however, meet a strong traditional norm for political behaviour – where solving concrete and immediate issues is central (Aberbach and Rochman 2000). On several occasions Parliament has engaged in issues that formally were be determined by the executive boards. The female lobby-group in the maternity cases is one obvious example. This shows that Parliament is quite uncertain about its new role. Intervention in single cases may be interpreted as an attempt to compensate for less control (Hood 1999), but with informal instruments that have no legitimate place in the new regime.

Seen from an *environmental perspective* one has to take into account the characteristics of the task environment represented by Parliament, local pressure groups, the media and lobbyism in order to understand how the trade-off between autonomy and control occurs in practice, and how it changes over time and between issues. Parliament has devoted more attention to health policy since the ownership of the hospitals was transferred. In 2002, the first year of the Reform, the number of questions in Parliamentary question time covering hospitals and enterprises doubled compared to the mean number during the six preceding years (Opedal, Rommetvedt and Winsvold 2003).

Increased political attention to health policies takes place in a period when Parliament in general has become more important vis-à-vis the Cabinet (Rommetvedt 1998, 2002, 2003, Nordby 2000, Espeli 1999). Over time Parliament has become more active and unpredictable. The nature of the electoral system in Norway makes multiple parties and turbulent parliamentary conditions likely, and this has been the typical situation during recent decades. This situation often reduces the influence of the executive because the negotiations between the parties in the parliament become crucial. This is a kind of "super-parliamentarism" representing a situation when the *Storting* is considered too dominant over government exertion of executive power (Christensen 2003; Rommetvedt 2002:69). State ownership combined with the present parliamentary situation (a minority government) can explain a greater political attention given to health policy. The Reform has strengthened the role of the MPs due to the fact that there is no longer any formal regional political influence over health policies. Besides, the Ministry has control over, and access to the entire range of policy instruments. (Previous responsibility was divided between central government and the counties.) The regional health enterprises are now regional owners and purchasers, and the local health enterprises are service suppliers. This has improved the conditions for vertical sector management and increased the power of central political actors while the former owners of the hospitals, the counties, have been relegated to the sideline.

The parliamentary situation and a holistic responsibility placed on central government are also prerequisites for an increased tendency of organized interest groups to direct their attention to and lobbying of Parliament (Holmefjord 1998, Christiansen and Rommetvedt 1999).

However, the attention of Parliament, (local) pressure groups and media is not only dependent on structural and parliamentary conditions. We argue that it also depends on policy type. The empirical foundation is the observation that while some health issues

seem to provoke only minor political engagement, others engender much turbulence and political debate. For instance, very little public and political attention has been paid to the allocation of financial resources from the regional health enterprises to the local enterprises. There has also been very little discussion about rules and guidelines for steering, control and resource allocation. According to these issues, the regional health enterprises have substantial autonomy and the politicians seem quite comfortable with their position at arm's length from the enterprises. Other health policy issues have, however, created considerable public attention and political controversy. Many questions raised in Parliamentary question time have been concerned with economic retrenchment and about closures and mergers of local health services, and, as we have also seen, especially about reorganization of maternity services in particular (Opedal, Rommetvedt and Winsvold 2002). When these types of issue are brought onto the agenda, politicians and pressure groups are on the alert, and try to influence or reverse decisions as some of the cases illustrate.

This phenomenon may be interpreted in terms of T. Lowi's typology of policy types and his idea that "policies determine politics"– that policy proposals structure politics (Lowi 1964, 1972). Lowi reversed the traditional conception in political science that politics determine policy outcomes (Roberts and Dean 1994). Lowi argues that different types of policy issues will constitute different policy arenas and processes, with different actors and degree of conflict or cooperation. Lowi's typology consists of four policy types: regulative policies, distributive policies, redistributive policies, and constituent policies. The potential of conflicts thus varies. When a policy has redistribution effects, winners and losers are especially significant, and the potential for conflict is high.

In our cases, professionals, local interest groups and politicians first and foremost have fought against closure of local hospitals or certain medical services. The politicians, though, have not only fought for their local hospital or service; they also try to maximise political support or voters (Schumpeter 1943, Downs 1957). When the counties owned the hospitals, the regional politicians hesitated to put issues that implied redistribution on the agenda (Opedal og Stigen 2002c). They determined the limits of cooperation, and thus prevented radical changes in the hospital structure.

State ownership leaves the regional health enterprises to decide on economic retrenchment and to undertake changes in geographical distribution of health services. Despite this, redistributive policies still harbour considerable potential for conflict, – triggering tension between central politicians and regional owners, and between decision makers and the surroundings encompassing pressure groups, media and local politicians.

Summing up, we have discussed three sets of factors that may explain ambiguity, instability and dynamics between political control and enterprise autonomy in a reform that is in an introduction and implementation phase. The structural, cultural and environmental aspects of the reform leave room for interpretation and adjustment and the trade-off between autonomy and control seems to be the result of a complex combination of deliberate choice, institutional constraints and external pressure. In a process of interpretation, adjustment and uncertainty there is a leeway for political and institutional norms to challenge and influence the relationship between political control and autonomy. The tension becomes especially pronounced when redistributive policy is put onto the agenda.

6 Political control and enterprise autonomy – both please?

The survey data and the cases studied revealed that there is a potential for ambiguity and conflict in the reform. The enterprises are loyal to the owner, but they also try to maximize autonomy. The politicians, on the other hand, experience loss of control when the enterprises live up to their autonomous role. The cases illustrate the conflict between a commercial logic, furthered by the regional health enterprises' enhancing efficiency and economy; and a political logic furthered by local, regional and central politicians, underlining the political problematic and at times utterly unacceptable effects of such a policy. In many cases autonomization is challenged by political intervention in single issues and by other political efforts in order to enhance political control.

The data presented reveal that in practice it may become difficult to live up to the principles of devolution and the official formal governance model of frame-steering and performance-management. The slogan "more steering in big issues and less steering in small issues" seems to be easier in theory than in practice. This is in line with experiences from other reforms (Christensen and Lægreid 2003a, 2003c; Pollitt 2002). The ministry is supposed to set policy objectives, to translate these into measurable targets and then actively monitor and review agencies and companies annually as they strive to reach the targets, and ultimately reward successes and penalize repeated failures. In many cases, though, this model gives an imprecise picture of what is occurring in practice. The ministries often set general objectives that are vague, contradictory and changing, involving unresolved trade-offs. The ministry frequently allows the agencies to set their own standards and targets and neglects to monitor these targets. However, when something goes wrong and there is media pressure or lobbying, the ministry can intervene and withdraw some of the liberties of the agencies, formulate new rules and reprimand the agencies for actions that really should have been discussed or clarified at target-setting time. The situation may imply that the Minister ends up in a "Catch-22 situation". If he or she abstains from involvement, he may be criticised for being too passive: if he does intervene, he may be accused for not complying with the rules of the game. The Health Reform has made the role of the health minister more complex, characterized by cross-pressure and conflicting expectations. This doesn't mean that the old system was perfect concerning central control and policy capacity, because the role of the counties was varied and ambiguous, and the focus on efficiency was weak.

One import question following this conclusion is whether it is possible to achieve a plus-sum game between control and autonomy? Stability in the trade-off between autonomy and control is probably an elusive goal and achieving a balance between the two has been a recurring problem in Norwegian administrative history (Grønlie 2001). An unstable balance is a basic systemic feature that cannot be solved once and for all. Instead, one must expect to live with partly conflicting values.

It therefore becomes a main challenge to find out which factors affect the trade-off between central control and local autonomy. In this paper we have focused on some structural factors, cultural factors and environmental factors linked to the parliamentary system in Norway. But type of policy issue and the political salience of the tasks and issues seem especially important. The cases clearly illustrate that we have to go beyond the legal status and formal powers of the agencies and the enterprises in order to understand how the balance between political control and autonomy works in practice (Christensen and Lægreid 2003b, Pollitt 2003b).

One main lesson is that context matters. The effects of structural arrangements, culture and the present parliamentary situation are dependent on the character of the policy issue that is on the agenda. If the issue has a redistributive character it seems especially challenging for the balance between political control and autonomy. What we are facing now is the ambiguity of the implementation phase and the optimistic argument is that once the balance of autonomy and control is fixed up in the new system it might be a better policy instrument. The more pessimistic forecast is that the underlying policy theory of the reform is based on a naïve assumption that it is possible to get rid of the political processes by introducing management principles and organizational forms from the private business sector, implying that the reform is doomed to be a failure in its initial version.

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